Alabama Medicaid Agency

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CAROL HERRMANN STECKEL, MPH
Commissioner

February 15, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2238-P
PO Box 8015
Baltimore, MD 21244-8015

To Whom It May Concern:

On behalf of the Alabama Medicaid Agency, I am writing in reference to the proposed rule (file code CMS-2238-P) that implements the provisions of the Deficit Reduction Act of 2005 (DRA) as it pertains to prescription drugs under the Medicaid program.

CMS proposes to exclude from AMP the prices of sales to long term care (LTC) pharmacies because "nursing home pharmacies do not dispense to the general public". However, Alabama, like many other state Medicaid Agencies, include LTC recipients in their coverage umbrella. Most of these recipients shifted to Part D in January 2006 for the majority of their drug claims, however, states are still required to compensate CMS for those claims through the clawback provisions. To not include sales to LTC pharmacies would reduce substantial financial benefits achieved by volume discounts obtained by LTC pharmacies.

Prices negotiated by a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage Plan (MA-PD) are excluded in the determination of best price. Again, Alabama, like many other States, carried the heavy pharmaceutical financial responsibility of these dual eligible recipients until the implementation of Medicare Part D. Unlike the States, the PDPs are not mandated to cover drugs in most non-optional drug classes, resulting in manufacturer competition and substantial discounted pricing agreements to the PDPs. To not include those negotiated prices by the Medicare PDPs and MA-PDs would reduce the substantial financial benefits brought forth by these competitive pricing agreements.

CMS clarifies that rebates paid to States under the Medicaid Drug Rebate Program should be excluded from AMP calculations but that price concessions associated with the sales of drugs in the retail pharmacy class of trade which are provided to Medicaid patients should be included. We would ask CMS to clarify supplemental State rebates (as in those associated with a Preferred Drug List) are included as well.

Utilizing the 12-month rolling average estimates of all lagged discounts for both the monthly and quarterly AMP would be beneficial to Alabama since it should reduce the number of times the manufacturer revises AMP. It should prevent AMP from fluctuating drastically from month to month. CMS also should make provisions to enforce the twelve quarter time limit in which a manufacturer can revise AMP.

We support using the 11 digit NDC when calculating AMP. This methodology will provide more accurate, realistic and useful pricing information. We agree that this method should not be significantly more difficult than using the nine-digit NDC and it will align AMP with state Medicaid drug payments that are based on package size.

The DRA requires for States to provide for the submission of claims data with respect to physician-administered drugs (both single source and multiple source drugs) using NDC numbers by January 1, 2007, with no FFP availability if these requirements are not met by January 1, 2008. There appears to be no provision to require the submittal of NDC numbers on Medicare related claims. Therefore, Medicaid may receive Medicare crossover claims for which no NDC number is available. Medicaid will also be required to collect rebate for these drugs. To retrieve NDC numbers after claims processing would present a great administrative burden on both the states and physicians who will be required to furnish the NDC numbers after the adjudication of the claim by Medicare. The proposed rule does not exclude Medicare crossover claims from Medicaid's requirement to collect rebates. If Medicare is not mandated to require claims submission of NDC numbers, then crossover claims should be excluded from the states' responsibility to collect rebates.

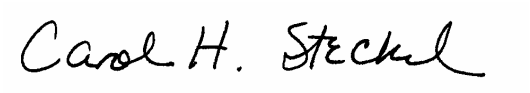
Alabama Medicaid has serious concerns regarding the reported savings and the monthly AMP information that has been sent to States from CMS via CD. In reviewing the monthly AMP information provided on the CD, we found numerous inconsistencies with unit pricing, obsolete NDCs, and otherwise unusable data resulting in extreme difficulty in reviewing and comparing the data on the AMP CD to our current pricing methodology. We understand that other States are experiencing similar difficulties with the inconsistent data on these CDs. Therefore, we believe the reported savings ($8 billion five-year total savings

from Federal Upper Payment Limits and other provisions, of which $3.3 billion is State originated) is overstated or at the very least inaccurate.

We are concerned about the overall impact these proposed changes would have on our pharmacy providers. CMS concludes that this proposed rule is likely to have a "significant impact" on some pharmacies. Pharmacies are a very valuable component to our heath care system and they play a vital role in helping us sustain adequate health care services for our recipients. Of most concern are those independent pharmacies serving in our rural areas, which are members of their independent buying association but cannot compete with large retail chains in their buying power. We request that CMS take into consideration the different classes of trade when determining impact of the DRA, particularly those pharmacy providers which service our rural areas.

Thank you for the opportunity to express our concerns and questions as it relates to the proposed rule on Medicaid prescription drug provisions that were included in the Deficit Reduction Act of 2005, and your careful consideration of our comments.

Regards,



Carol H. Steckel
Commissioner

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